U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 24Jun2002

In the Matter of:	:	
	:	
WILLIAM C. GRIFFITH,	:	Case No: 1999-BLA-219
Claimant,	:	
	:	
v.	:	
	:	
STERLING SMOKELESS COAL CO.,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS,	:	
Party-in-Interest	:	
	:	

S.F. Raymond Smith, Esquire
For the Claimant

Mark E. Solomons, Esquire
For the Employer

Francine A. Serafin, Esquire
For the Director, OWCP

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER ON REMAND--DENYING BENEFITS

Statement of the Case[1]

This case was remanded to this tribunal by unpublished decision and order of the Benefits Review Board dated January 22, 2001, vacating this tribunal's findings that Claimant established all elements of entitlement, and was, therefore, entitled to benefits under the Act. On remand, the Board directed this tribunal to weigh all types of relevant evidence together at §718.202(a)(1)-(4) to determine whether Claimant has established the existence of pneumoconiosis as required by *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000). Additionally, inasmuch as the Board vacated this tribunal's finding that the Claimant established the existence of pneumoconiosis, it also vacated this tribunal's finding that the Claimant is entitled to the presumption of pneumoconiosis arising out of coal mine employment pursuant to §718.203(b). On remand, if this tribunal again finds the existence of pneumoconiosis, the Board directed this tribunal to consider whether the presumption of pneumoconiosis arising out of coal mine employment pursuant to §718.203(b) has been rebutted. The Board also vacated this tribunal's findings pursuant to §718.204(b) and (c), that the Claimant is totally disabled by his pneumoconiosis, and directed it to weigh all relevant evidence, like and unlike, pursuant to §718.204(c). The Board further directed that, if this tribunal finds that the Claimant is totally disabled by a respiratory or pulmonary impairment, it must then reconsider whether such total disability is due to the Claimant's pneumoconiosis pursuant to §718.204(b). The Board affirmed this tribunal's finding that Sterling Smokeless Coal Company (Employer) is the properly designated responsible operator.

This proceeding involves a first subsequent or duplicate claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 *et seq.* ("the Act"), and the regulations promulgated thereunder.[2] Since this claim was filed in 1994, Part 718 applies. Because the Claimant was last employed in the coal industry in West Virginia, the law of the Fourth Circuit of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*). Claimant is and has been receiving black lung benefits since the entitlement date of July 1,1994, pursuant to the September 30, 1999 finding of entitlement by this tribunal. Employer's appeal resulted in the instant remand.

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[1] Unless otherwise specified, in this section, citations to the applicable regulations refer to the pre-amended regulations. The merits of the claim, however, are decided pursuant to the amendments to Part 718, published in Fed. Regis./Vol. 65, No. 245, Wed., Dec. 20, 2000, which became effective on January 19, 2001, and which are applicable in accordance with their terms to this claim which was pending on the effective date of the amended regulations.

[2] All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "D-"; Claimant's Exhibits are denoted "C-"; Employer's Exhibits are denoted "E-"; and citations to the hearing transcript are denoted "Tr."

Issues

1. Whether Claimant has established a material change in conditions pursuant to §725.309?

2. If so, whether Claimant has established the other elements of entitlement to benefits under Part 718, namely, the existence of pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that he is totally disabled due to pneumoconiosis.

Findings of Fact and Conclusions of Law

Background, Length of Coal Mine Employment, and Smoking History

The Claimant, William C. Griffith, was born on April 20, 1943, and possesses an eighth grade education (D-1). For the purpose of augmentation of benefits under the Act, Claimant has one dependent, his wife, Barbara. (D-1, 8). Claimant has established at least eighteen years of coal mine employment, ending in 1985 (D-1, 4; Tr. 6). Claimant's last coal mine employment was as a drill operator and shot foreman (D-7; Tr. 12). As a drill operator and shot foreman, the Claimant would drill holes, insert explosives, and set the explosives off. Claimant was required to lift and drag fifty pound bags of powder to the coal face, to shovel during clean up, and to move rock dust, which required him to carry fifty pound rock dust bags approximately fifty feet. (D-7, 10, 28, 51). Accordingly, this position required moderate to heavy manual labor. At the time of the hearing, Claimant was employed as a backhoe operator and truck driver in road construction (D-7, Tr. 10). Claimant testified that he has worked in this position "off and on" for thirteen years (Tr. 10). He also testified that this position does not require any strenuous work, and that he primarily drives a truck (Tr. 10).

Claimant began smoking in the early sixties and smoked at a rate of approximately one pack of cigarettes per day until the early 1990's, when he cut down to less than one-half pack per day (D-10; E-1). By June of 1998, Claimant was smoking one pack of cigarettes per week (D-51). He quit smoking in October 1998 (Tr. 21).

Medical Evidence

X-ray Evidence[3]

Exh. No.	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
D-12, 14	9/7/94	9/7/94	Patel R	1/2, q/p; ill defined diaphragm
D-13	9/7/94	11/2/94	Gaziano B	1/0, t/t; ill defined diaphragm
E-5	9/7/94	3/12/99	Wheeler B/.R	0/0
E-5	9/7/94	3/4/99	Scott B/R	0/0
E-5	9/7/94	3/4/99	Gayler B/R	0/0
E-1	10/11/94	10/11/94	Daniel	2/2, r/u; emphysema; arteriosclerotic vascular disease
E-5	10/11/94	3/16/99	Wheeler B/R	0/0
E-5	10/11/94	3/15/00	Scott B/R	0/0
E-5	10/11/94	3/15/99	Gayler B/R	0/0, abnormality of cardiac size or shape
D-28	2/10/95	2/10/95	Ranavaya B	1/1, p/q
D-26	2/22/95	--	Wills R	"coal workers' pneumoconiosis"
E-5	2/22/95	3/16/99	Wheeler B/R	0/0
E-5	2/22/95	3/15/99	Scott B/R	0/1, q/t
E-5	2/22/95	3/15/99	Gayler B/R	0/0; abnormality of cardiac size or shape
E-5	10/6/95	3/16/99	Wheeler B/R	0/0
E-5	10/6/95	3/15/99	Scott B/R	0/1, q/t; discoid atelectasis or linear scar left lower lung

[3] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis. The credentials of Drs. Wills, Ahmed, and Miller are not of record. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. This tribunal also take judicial notice that Drs. Ahmed and Miller are listed as B-readers on the list of NIOSH Approved Readers. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

Exh. No.	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
E-5	10/6/95	3/15/99	Gayler B/R	0/0; abnormality of cardiac size or shape
E-5	5/3/97	3/16/99	Wheeler B/R	0/0; minimal pleural fibrosis or pleural effusion blunting right CPA; probable few small nodules compatible with healed TB more likely than healed histoplasmosis; subtle thickening lateral portion minor fissure from fibrosis or thin pleural effusion
E-5	5/3/97	3/15/99	Scott B/R	0/1, q/t; possible pleural effusion; densities in 2B probably due to healed TB
E-5	5/3/97	3/15/99	Gayler B/R	0/0; abnormality of cardiac size or shape; few small upper lobe densities probably healed tb
D-51	6/3/98	6/26/98	Zaldivar B	1/1, q/q; effusion; evidence of right pleural thickening and costophrenic blunting
C-1	6/3/98	6/4/99	Aycoth B	2/3, q/t; bilateral pleural thickening
C-1	6/3/98	6/15/99	Ahmed B/R	2/1, q/r; emphysema; thickening of the minor fissure
C-1	6/3/98	6/3/99	Miller B/R	2/2, q/r; blunting of right costophrenic angle--? effusion versus pleural reaction; thickening of the minor fissure
E-5	6/3/98	3/16/99	Wheeler B/R	0/0; small pleural effusion or possible pleural fibrosis blunting right CPA; slight thickening minor fissure or interlobar effusion; few tiny nodules compatible with healed TB
E-5	6/3/98	3/15/99	Scott B/R	0/1, q/r; probable small right pleural effusion extending into minor fissure
E-5	6/3/98	3/15/99	Gayler B/R	0/0; abnormality of cardiac size or shape; few small upper lobe densities probably healed TB
E-5	8/29/98	3/16/99	Wheeler B/R	0/0; minimal pleural fibrosis or extra pleural fat on both lateral chest walls and minimal fibrosis or interlobar effusion minor fissure; vertical linear discoid atelectasis or scar in right CPA; few small nodules compatible with healed TB
E-5	8/29/98	3/15/99	Scott B/R	0/1, q/r; slight thickening minor fissure; probable subpleural fact lateral chest walls versus pleural fibrosis
E-5	8/29/98	3/15/99	Gayler B/R	0/0; nodule R mid lung, rec. CT; old granulomas

Pulmonary Function Studies [4, 5]

Exh. No.	Test Date	Age/ Ht.	Co-op./Undst./ Tracings	FEV1	MVV	FVC	Qualify
D-9	9/7/94	51/73.5"	Good/Good/Yes	3.08 3.38	111 122	4.31 4.50	No No
D-28	2/10/95	51/74"	Good/Good/Yes	2.64 2.85	92.7 93.5	3.58 3.91	No No
D-26	2/22/95	51/74"	Good/---/Yes	2.73 2.46	91 100	3.71 3.35	No No
D-51	6/3/98	55/74"	---/---/Yes	2.51 2.61	103 103	4.11 4.09	No No

Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed the February 10, 1995 spirometry and opined that it was invalid due to premature termination to exhalation and a lack of reproducibility in the expiratory tracings. He also noted a lack of an abrupt onset to exhalation. Dr. Fino opined that the values recorded for this spirometry represent at least the minimal lung function that Claimant could perform and not his maximum lung function. Dr. Fino also concluded that the MVV was invalid due to shallow and erratic individual breath volumes. He opined that the MVV value underestimates the Claimant's true lung function. Dr. Fino cited literature relevant to the standardization of spirometry. (E-2).

Dr. Fino reviewed the February 22, 1995 spirometry and found it invalid due to a premature termination of exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. He opined that the spirometric values do not represent the Claimant's maximum lung function. Dr. Fino also concluded that the MVV was invalid due to individual breath volumes which were erratic, shallow, and less than 50% of the forced vital capacity. (E-2).

Arterial Blood Gas Studies [6]

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[4] Second set of entries on the same test relates to results after administration of bronchodilators.

[5] Pursuant to §718.103 and Appendix B to Part 718, conforming pulmonary function studies require that the miner's level of cooperation and understanding of the procedures be recorded, and that the record of the studies include three tracings. To be qualifying, the FEV1 as well as the MVV or FVC values must equal or fall below the applicable table values found at Part 718, Appendices B and C.

[6] Second set of entries, if any, on the same test relates to results after administration of exercise. Blood gas tables at Appendix C of Part 718 do not permit "rounding up" or "rounding down" of pCO_2 or pO_2 values to

Exhibit No.	Test Date	pCO_2	pO_2	Conform	Qualify
D-11	9/7/94	41	73	Yes	No
		41	65	Yes	No
D-28	2/10/95	41.4	74.4	Yes	No
D-26	2/22/95	35	76	Yes	No
D-51	6/3/98	38	74	Yes	No
		39	74	Yes	No

Physicians' Opinions[7]

Dr. Rasmussen, board-certified in internal medicine, examined Claimant on September 7, 1994. (D-10). Dr. Rasmussen recorded a twenty-four year coal mine employment history, lastly as a shot foreman and coal driller, a position he noted as requiring considerable heavy manual labor. Claimant reported to the doctor that he had smoked one pack of cigarettes per day since 1963, and had smoked less than one-half pack per day for the last five years. Dr. Rasmussen opined that Claimant's pulmonary function studies evidenced a slight, irreversible obstructive impairment, his arterial blood gas tests revealed a moderate impairment in oxygen transfer during exercise, and that he had x-ray changes consistent with pneumoconiosis. Based on these findings in addition to Claimant's occupational and smoking histories, Dr. Rasmussen opined that Claimant has coal workers' pneumoconiosis caused by coal mine dust exposure and chronic bronchitis caused by dust exposure and cigarette smoking. Dr. Rasmussen further opined that Claimant's minimal to moderate loss of respiratory functional capacity, as reflected principally by the impairment in oxygen transfer during exercise, renders him incapable of performing very heavy manual labor. Dr. Rasmussen stated that the two risk factors for the Claimant's impaired respiratory function are his cigarette smoking and coal mine dust exposure, with the latter being at least a major contributing factor.

Dr. Ranavaya, board-certified in occupational medicine, examined Claimant on February 10, 1995, and reviewed additional specified medical records for his report erroneously dated January 25, 1995 . (D-28). Dr. Ranavaya noted that Claimant smoked approximately one pack of cigarettes every four days since 1960 and worked in the coal mine industry for twenty-four years, lastly as a coal driller and shot foreman, a job that required a great deal of lifting, pushing, pulling, and crawling. Among other things, Claimant reported diagnoses of emphysema in 1982 and heart problems in 1994. Dr. Ranavaya opined that Claimant's pulmonary function studies revealed mild to moderate pulmonary impairment, reflected by a combined ventilatory defect seen on spirometry

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determine whether the test is qualifying: rather, each value must be "equal to or less than" the applicable table value. *Tucker v. Director, OWCP*, 10 BLR 1-35 (1987).

[7]The credentials of Drs. Rasmussen and Daniel are not of record. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

and hypoxemia observed on arterial blood gas analysis at rest. Dr. Ranavaya also opined that Claimant has radiological evidence of pneumoconiosis. Based on these findings, Dr. Ranavaya concluded that Claimant is totally disabled from resuming his former coal mine employment or any other job with similar exertional demands. Dr. Ranavaya further opined that it was reasonable to conclude that Claimant's pulmonary insufficiency arose primarily from his coal dust exposure. On June 1, 1999, Dr. Ranavaya prepared a consultative report, for which he reviewed specified medical evidence, and affirmed the conclusions reached in his prior report. (C-1).

Dr. Daniel, board-certified in family practice, examined Claimant on February 22, 1995. (D-26). Dr. Daniel recorded a twenty-four year coal mine employment history, primarily as a machine operator and lastly as a mine foreman and drill operator. He noted that Claimant was presently smoking and had been smoking one pack of cigarettes every four days for the past thirty years. Claimant reported a history of heart disease. Based on Claimant's work history and chest x-ray, interpreted as positive for pneumoconiosis, Dr. Daniel opined that Claimant has coal worker's pneumoconiosis. Dr. Daniel interpreted the pre- and post-bronchodilator pulmonary function studies as indicative of a moderate restrictive defect and mild obstructive defect. He noted that Claimant's EKG was consistent with a history of arteriosclerotic heart disease. Claimant's history of angina and EKG contraindicated exercise testing, but Claimant's resting arterial blood gases were normal. Dr. Daniel diagnosed chronic obstructive lung disease, coal workers' pneumoconiosis, arteriosclerotic heart disease, and hyperlipidemia by history. Dr. Daniel opined that Claimant's pulmonary function studies show evidence of obstructive ventilatory defect secondary to smoking; however, in view of the evidence before him, he found no evidence of significant pulmonary function impairment based on testing. Therefore, Dr. Daniel concluded that Claimant could continue his job as a mine foreman without endangering his health from a pulmonary standpoint. However, he opined that Claimant's heart condition is probably disabling. Dr. Daniel stated that Claimant's arteriosclerotic heart disease is not connected to his former coal mine employment.

Dr. Cohen, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his June 27, 1995 report. (D-28). Dr. Cohen opined that Claimant has coal workers' pneumoconiosis based on: the Claimant's coal mine employment history; his symptoms of chronic lung disease dating back over a decade; pulmonary function testing indicating a mild to moderate restrictive process, a process which can be caused by the scarring and tissue damage from coal dust in classical medical coal workers' pneumoconiosis; cardiopulmonary exercise testing demonstrating a low work capacity and moderate oxygen transfer impairment and hypoxemia; the absence of a history of other occupational exposure or cause of obstructive lung disease other than coal dust and cigarette smoke; radiographic evidence; and the absence of significant cardiac disease. Dr. Cohen also opined that all of Claimant's pulmonary function studies showed that Claimant has a mild to moderate restriction by spirometry and mild obstructive lung disease. He declared that it is well known that coal dust exposure causes simple coal workers' pneumoconiosis, which causes restrictive lung diseases like that seen on the Claimant's spirometry. Dr. Cohen also stated that there are two possible causes for Claimant's obstructive lung disease: his thirty pack-year smoking history and significant exposure to coal dust. Dr. Cohen cited medical literature in support of the conclusion that obstructive lung diseases can be caused by coal dust exposure. Upon consideration of the requirements of Claimant's last coal mine employment, Dr.

Cohen opined that Claimant does not have the ventilatory capacity to perform that type of work. Dr. Cohen opined that Claimant's twenty-four years of coal mine employment were "significantly contributory" to the development of his restrictive lung disease, gas exchange abnormality with exercise and low work capacity, and his obstructive lung disease. Dr. Cohen also identified Claimant's significant smoking history and exposure to tobacco as a contributing factor to the development of Claimant's obstructive lung disease.

Dr. George L. Zaldivar, board-certified in internal medicine and the subspecialty of pulmonary diseases, examined Claimant on June 3, 1998, and reviewed specified medical evidence for his July 2, 1998 report. (D-51). Dr. Zaldivar recorded a twenty-four year coal mine employment history, lastly as a shot fireman [foreman]. Dr. Zaldivar noted that, for the last five years, Claimant reduced his smoking from one and one-half packs of cigarettes per day to about one pack per week. Based on his review of the radiographic evidence, Dr. Zaldivar opined that Claimant has "very early radiographic pneumoconiosis." Dr. Zaldivar also found that Claimant has a mild airway obstruction which is the result of his past and present smoking history, and mild restrictive impairment produced by the right pleural thickening and fibrosis which is a result of previous injury to the lung in the form of pneumonia. Dr. Zaldivar declared that Dr. Cohen's statement that coal workers' pneumoconiosis is known to cause restrictive lung disease is not correct. Instead, Dr. Zaldivar stated, "Coal workers' pneumoconiosis when it causes impairment causes an airway obstruction and not a restriction." Dr. Zaldivar opined that, even though Claimant has radiographic evidence of simple pneumoconiosis, he has the pulmonary capacity to perform not only his current work, but also heavy manual labor. However, Dr. Zaldivar noted that as a smoker and overweight individual, Claimant's exercise capacity will be limited by these factors which are unrelated to his occupation as a miner. Upon review of additional medical evidence Dr. Zaldivar affirmed his findings in a report dated March 25, 1999 (E-4). Dr. Zaldivar was deposed on April 12, 1999. (E-7). In addition to reiterating his prior findings, Dr. Zaldivar explained that restriction is only caused by coal dust when there is progressive massive fibrosis, when the lungs are affected by huge masses of conglomerate opacities, and that restriction is not associated with simple coal workers' pneumoconiosis (E-7 at 19-20).

Dr. Tuteur, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his March 26, 1999 report. (E-3). Dr. Tuteur opined that Claimant does not have clinically significant, physiologically significant, or even radiographically significant coal workers' pneumoconiosis. Furthermore, Dr. Tuteur opined that even if coal workers' pneumoconiosis were present to a sufficient degree to produce radiographic abnormalities, its severity and profusion would be insufficient to produce clinical symptoms. Dr. Tuteur concluded that Claimant has primary pulmonary disease. He opined that Claimant's chronic daily productive cough associated with wheezing and changing chest examination superimposed on over three decades of smoking constitute a clinical diagnosis of cigarette smoke induced chronic bronchitis. Dr. Tuteur explained that breathlessness is the quintessential clinical feature of coal worker's pneumoconiosis. He also explained that while the Claimant experiences breathlessness, breathlessness is also a highly nonspecific finding consistent with virtually any primary pulmonary or cardiac disorder.

Dr. Tuteur ruled out the Claimant's cardiac disorder as a cause for his breathlessness because

testing indicated that Claimant's disorder was trivial and that he had normal function. In contrast, Dr. Tuteur noted that cigarette smoke induced chronic obstructive pulmonary disease is associated with Claimant's moderate obstructive ventilatory defect, his variable and recently improved gas exchange, and his symptoms of breathlessness, cough expectoration, wheezing and chest pain. Dr. Tuteur also remarked that cough, wheezing, expectoration, and chest pain are not regular features of coal workers' pneumoconiosis. Based on review of pulmonary function and arterial blood gas studies performed between 1994 and 1998, Dr. Tuteur noted that Claimant has experienced "a progressive obstructive ventilatory defect associated with variable impairment of gas exchange during exercise, improving over time, and a measured reduced total lung capacity using a gas dilution technique inappropriate and regulary falsely low in persons with airways obstruction." He then explained that when coal workers' pneumoconiosis is sufficiently advanced to produce pulmonary function impairment, one expects to find an irreversible abnormality, including irreversible impairment of gas exchange first seen during exercise then at rest. This, he reiterated, was not the case for the Claimant. Dr. Tuteur concluded that Claimant's symptomology indicates that he is totally disabled from performing the requirements of his last coal mine employment, and attributed this disability to "cigarette smoke-induced chronic obstructive pulmonary disease. . .aggravated by his obese physiognomy." Dr. Tuteur opined that Claimant's pulmonary condition is in no way related to, aggravated by, or caused by the inhalation of coal mine dust. Dr. Tuteur provided a critical review of the medical literature cited by Dr. Cohen in his June 27, 1995 report. Dr. Tuteur affirmed his conclusions in a deposition taken on April 13, 1999. (E-6). However, when asked directly if the Claimant is disabled from a pulmonary standpoint, Dr. Tuteur stated that he is not (E-6 at 12).

Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his March 30, 1999 report. (E-2). Dr. Fino first explained that the chest x-ray readings of record were predominantly negative for coal workers' pneumoconiosis, but for the purposes of discussion, he would assume that simple pneumoconiosis was present. Based on his review of test results, Dr. Fino opined that Claimant has obstructive bronchitis and emphysema due to cigarette smoking. Dr. Fino further opined that from a respiratory standpoint, Claimant is neither partially nor totally disabled from returning to his last coal mining job or a job requiring similar effort.

Dr. Fino reiterated and elaborated upon his opinions in a deposition taken on April 29, 1999. (E-8). Dr. Fino also clarified his opinion concerning whether Claimant suffers from pneumoconiosis. Dr. Fino explained that in his report dated March 30, 1999, he assumed Claimant had pneumoconiosis based on Dr. Zaldivar's x-ray reading. However, this assumption was merely for the sake of argument, and Dr. Fino opined in his deposition that Claimant does not have pneumoconiosis. (E-8 at 8-10). Dr. Fino also elaborated upon his finding that the Claimant is not totally disabled by a respiratory or pulmonary impairment. He began by stating that one must rely on the objective testing to determine pulmonary disability. Utilizing the pulmonary function study administered by Dr. Zaldivar, Dr. Fino explained that the Claimant exhibited a moderate obstruction with a minimally reduced MVV. He then explained that the tracings from Claimant's exercise arterial blood gas study for Dr. Zaldivar indicated no decrease in the blood oxygen level with exercise, which indicated that there was no oxygen transfer abnormality, and that for the amount of

exercise that was performed, the Claimant's lungs were normal. Thus, Dr. Fino opined that from a strictly pulmonary standpoint, while an impairment is present, it is an obstructive type abnormality not of sufficient degree to prevent the Claimant from returning to his former coal mine employment or a job requiring similar effort. (E-8 at 10-12). Dr. Fino understood that while Claimant's last job involved some heavy labor, it was not the degree of heavy labor or duration of heavy labor that would prevent the Claimant from performing it due to his lungs (E-8 at 12). Dr. Fino ruled out Claimant's coal mine dust exposure as a cause of his pulmonary impairment, explaining in detail that the Claimant's impairment is multifactoral, related to his cigarette smoking and obesity, and that Claimant's impairment is not the type of impairment expected to be seen with coal dust exposure (E-8 at 14-16).

The Claim of Total Disability Due to Coal Workers' Pneumoconiosis

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act.

Subsequent or Duplicate Claim

Since the instant claim was filed more than one year after the denial of Claimant's previous claim, it is considered a duplicate or subsequent claim under the Act and regulations. §725.309. Under the pre-amended regulations, which apply to this case pursuant to §725.2(c), a subsequent claim shall be denied on the grounds of the prior denial unless the claimant demonstrates that there has been a material change in conditions. §725.309(d) (pre-amended). To prove a material change of conditions, a claimant must prove, under all of the favorable and unfavorable probative medical evidence of his condition after the prior denial, at least one of the elements previously adjudicated against him. *Lisa Lee Mines v. Director, OWCP*, [Rutter], 86 F.3d 1358, 20 BLR 2-227 (4th Cir. 1996) (*en banc)*. Claimant's original claim was denied on grounds that he had failed to establish the existence of pneumoconiosis or total disability. Therefore Claimant, in order to demonstrate a material change in conditions must, as a matter of law, prove either one of these elements.

Existence of Pneumoconiosis

For purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis. §718. 201(a). Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§ 718.304, 718.305, 718.306; or (4) the finding by a physician of pneumoconiosis as defined in § 718.201 which is based upon objective evidence and a reasoned medical opinion. The record contains no evidence of a biopsy, and the presumptions under §§ 718.304, 718.305, and 718.306 are inapposite, because there is no evidence of complicated pneumoconiosis, the claim was filed after 1981, and because the miner is living.

The existence of pneumoconiosis requires consideration of "all relevant evidence" under §718.202(a), as specified in the Act. Thus, if a record contains both relevant x-ray interpretations and biopsy reports, the Act would prohibit a determination based on x-ray alone, or without evaluation of physicians' opinions that the miner suffered from "legal" pneumoconiosis. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 BLR 2-104 (3d Cir. 1997).

In its previous decision and order in this claim, this tribunal found that the overwhelming majority of the thirty readings of the eight x-rays of record were interpreted by physicians with superior credentials as negative for pneumoconiosis, and, accordingly, found that Claimant failed to establish the existence of pneumoconiosis by a preponderance of the x-ray evidence under §718.202(a)(1). However, this tribunal found that, because the majority of the physicians of record who offered opinions based on the objective medical evidence obtained from their examinations of the Claimant and one who reviewed pertinent medical evidence opined that the Claimant has coal workers' pneumoconiosis, Claimant established that he has pneumoconiosis pursuant to §718.202(a)(4). This tribunal found the opinions of Drs. Fino and Tuteur less convincing because they did not examine the Claimant and based their opinions that the Claimant does not have pneumoconiosis solely on the numerical superiority of the negative x-ray evidence. On remand, the Benefits Review Board specifically instructed this tribunal to reconsider all of the evidence under the four prongs of §718.202(a) together, in accordance with *Compton*, and redetermine whether the Claimant has established the existence of pneumoconiosis.

The eight x-rays of record were interpreted a total of thirty times by two radiologists, four B-readers, and five dually qualified board-certified radiologists and B-readers. The nine positive readings were provided by four B-readers, two radiologists, two dually -qualified board-certified radiologists and B-readers, and one physician of undetermined credentials. The remaining twenty-one negative interpretations were provided by three dually qualified board-certified radiologists, Drs. Wheeler, Scott, and Gayler, who each interpreted seven films in a series. Accordingly, the overwhelming numerical preponderance of the x-rays were interpreted as negative by physicians of superior credentials, and because this tribunal may defer to the numerical superiority of the x-ray evidence, its analysis may end here with a finding that the x-ray evidence does not establish the existence of pneumoconiosis. *Edmiston v. F & R Coal Co.*, 14 BLR 1-65 (1990). However, this tribunal is not persuaded by the numbers alone, and finds most persuasive the dually-qualified physicians' interpretations of the films as a series. It is evident from the reading dates that Drs. Wheeler, Scott, and Gayler each interpreted the first of the seven films dated from September 1994 through August 1998, and then, interpreted the remaining six films in a single day less than two weeks thereafter. Therefore, these physicians were able to compare the films and consider a more complete record of the Claimant's condition over time. The remaining nine physicians of record interpreted only one film each. Therefore, this tribunal finds that the preponderance of negative interpretations of the x-rays by superiorly qualified interpreters who evaluated the Claimant's condition over time precludes proof of pneumoconiosis by a preponderance of the x-ray evidence. Therefore, the x-ray evidence, in and of itself, does not establish that the Claimant has pneumoconiosis under §718.202(a)(1).

A determination of the existence of pneumoconiosis may be made pursuant to §718.202(a)(4) if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding must be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories, and be supported by a reasoned medical opinion.

This tribunal is not bound to accept the opinion or theory of any given medical officer, but may weigh the medical evidence and draw its own inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 BLR 1-190 (1989); *Kertesz v. Crescent Hills Coal Co.*, 8 BLR 1-112 (1985); *see Markus v. Old Ben Coal Co.*, 712 F.2d 322, 326, 5 BLR 2-130, 2-136 (7th Cir. 1983). A reasoned medical opinion is one in which the physician sets forth the evidence he relies upon in reaching his conclusion. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). In making this determination, this tribunal must "examine the validity of the reasoning of a medical opinion in light of the studies conducted and the objective limitations upon which the medical opinion or conclusion is based." *Director, OWCP, v. Siwiec*, 894 F.2d 635, 639, 13 BLR 2-259 (3d Cir. 1990). A well reasoned opinion is defined as one in which the documentation as a whole supports the physician's conclusions. *Phillips v. Director, OWCP*, 768 F.2d 892, 8 BLR 2-16 (8th Cir. 1985).

Of the seven physicians who have provided opinions in this case, five of them, Drs. Zaldivar, Rasmussen, Ranavaya, Cohen, and Daniel, opined that Claimant has pneumoconiosis. Dr. Rasmussen, board-certified in internal medicine, Dr. Daniel, board-certified in family practice, and Dr. Ranavaya, board-certified in occupational medicine, based their opinions on the Claimant's reported twenty-four years of coal mine employment and positive x-ray evidence (D-10, 25, 28). This tribunal has found that Claimant only established at least eighteen years of coal mine employment, and that the overwhelming majority of the x-ray evidence is negative for pneumoconiosis. Moreover, the single x-ray upon which Dr. Daniel based his findings is not of record. Accordingly, although the opinions of Drs. Rasmussen, Daniel, and Ranavaya are entitled to some weight because they are well-reasoned based on the evidence before them, they are not controlling based on their consideration of a slightly inflated coal mine employment history and inconsistency with the preponderance of the x-ray evidence. Dr. Zaldivar, board-certified in internal medicine and the subspecialty of pulmonary diseases, opined that the Claimant has very early radiographic evidence of coal workers' pneumoconiosis based on the x-ray evidence (D-51). Although he based his opinion on x-ray evidence determined by this tribunal to be unpersuasive in light of the entirety of the x-ray evidence, Dr. Zaldivar's opinion is entitled to some weight based on his well-reasoned opinion and his superior credentials in pulmonary medicine. Dr. Cohen, board-certified in internal medicine and the subspecialty of pulmonary diseases, based his finding of pneumoconiosis on extensive objective medical evidence including the Claimant's coal mine employment history, x-rays, physiologic testing, and symptomology (D-28). Dr. Cohen presented a reasoned and documented opinion based on review of the evidence before him, and given his superior credentials in pulmonolgy, Dr. Cohen's opinion is entitled to substantial weight.

Drs. Tuteur and Fino, both board-certified in internal medicine and the subspecialty of

pulmonary diseases, reviewed extensive medical evidence and opined that the Claimant does not have pneumoconiosis. Based on the data before him, Dr. Tuteur concluded that the radiographic evidence was inconsistent and that a more definitive evaluation was required to determine whether the Claimant has pneumoconiosis. However, he also explained in a detailed and well-reasoned and documented opinion that Claimant's physical examination was uncharacteristic of pneumoconiosis in any form (E-3, 6 at 9-12). Accordingly, Dr. Tuteur's opinion is entitled to substantial weight. Dr. Fino utilized the Claimant's radiographic and physiologic testing evidence to rule out the presence of pneumoconiosis, noting that Claimant's pulmonary function study results were atypical of industrial bronchitis or chronic obstructive pulmonary disease due to coal mine dust inhalation (E-8 at 7-9 and 15-16). Dr. Fino's well reasoned and articulated opinion is also entitled to substantial weight.

The evidence under §718.202(a)(4) is, at best, in equipoise. However, given this tribunal's findings in regard to the radiographic evidence, and in critical consideration of the opinions of the three qualified pulmonary physicians who based their opinions on evidence other than the x-ray evidence, this tribunal finds that the more persuasive evidence establishes that the Claimant does not have pneumoconiosis. To reiterate, the preponderance of the radiographic evidence does not indicate that the Claimant has radiographic evidence of clinical pneumoconiosis. Although three physicians opined to the contrary, none of those physicians are credentialed in pulmonary medicine, and all considered an inflated coal mine employment history. Accordingly, their opinions do not establish finding of clinical pneumoconiosis. Similarly, Dr. Zaldivar's finding of very early radiographic evidence of coal workers pneumoconiosis is unpersuasive in light of the entirety of the radiographic evidence. Only Dr. Rasmussen opined that Claimant has a legal form of pneumoconiosis: chronic bronchitis caused by cigarette smoking and coal mine dust exposure. However, because Dr. Rasmussen based his diagnosis of chronic bronchitis on Claimant's self-reported history of chronic productive cough, and not on the objective evidence of record, and because he did not provide a rationale for his conclusion that the Claimant's chronic bronchitis was caused by exposure to coal dust, his opinion in regard to the existence of legal pneumoconiosis is unpersuasive.

Although Dr. Cohen's opinion is well-documented, it reflects an incomplete consideration of critical evidence, and is outweighed by the better reasoned opinion of Dr. Tuteur. While Dr. Cohen based his finding of pneumoconiosis on the Claimant's pulmonary function testing evidencing moderate restrictive and mild obstructive impairments, Dr. Cohen did not indicate that he reviewed Claimant's post-bronchodilator testing (D-28, pages 5-6 of his report). Moreover, Dr. Cohen's analysis of the physiologic testing was limited to testing administered during a six month period from September 1994 through February 1995. He did not review Claimant's most recent testing from June 1998. Alternatively, Dr. Tuteur reviewed all four sets of physiologic testing, and explained in detail that the evidence indicates that Claimant's pulmonary function impairment is not an irreversible impairment as evidenced by response to bronchodilators and reversible gas exchange impairment, a finding atypical of pneumoconiosis (E-3, 6 at 9-10). Accordingly, because he considered extensive, complete, and more recent objective evidence, Dr. Tuteur's opinion is more persuasive than that of Dr. Cohen. Therefore, the preponderance of the reasoned medical opinions provided by superiorly credentialed physicians indicates that the Claimant does not have pneumoconiosis in either a clinical

or legal form.

Thus, both the x-ray evidence and physician's opinions indicate that the Claimant does not have pneumoconiosis in either the clinical or legal form. Although this tribunal previously found that the medical opinions of examining physicians, Drs. Rasmussen, Daniel, Ranavaya, and Zaldivar, were more probative, this tribunal now finds, based on re-examination of all the opinions of record in additional to further consideration of the physicians' credentials and the entirely of the radiographic evidence, that the opinions of the non-examining physicians who were able to review extensive medical evidence accumulated over a four-year period are most persuasive. Therefore, this tribunal finds that the entirety of the evidence under §718.202(a) does not establish by a preponderance that the Claimant has coal workers' pneumoconiosis. Therefore, Claimant has not established a material change in conditions in this regard since the denial of his initial claim.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established at least eighteen years of coal mine employment. Thus, had he established the existence of pneumoconiosis, he would have also been entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of §718.203(b). But, because he has not established the existence of pneumoconiosis, the issue is moot.

Total Disability

To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Specifically, §718.204(b)(1) provides that a miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment, which, standing alone, prevents him from performing his usual coal mine work and prevents him from engaging in gainful employment in the immediate area of his residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he previously engaged with some regularity over a substantial period of time. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

In its previous decision and order in this claim, this tribunal found that, while all of Claimant's pulmonary function and arterial blood gas studies produced non-qualifying results, the medical opinions of Drs. Rasmussen and Ranavaya, who examined the Claimant and have superior credentials, supported a finding that the Claimant was totally disabled due to pneumoconiosis. This tribunal found the opinions of Drs. Cohen, Fino, and Tuteur less persuasive because they did not examine the Claimant. It also found less persuasive Dr. Zaldivar's opinion based on his statement that "simple coal workers' pneumoconiosis never causes a restrictive impairment," which is contrary to established law and the purposes of the Act. *See Warth v. Southern Ohio Coal co.*, 60 F.3d 173 (4th Cir. 1995). On remand, the Board affirmed this tribunal's findings with regard to Dr. Zaldivar's opinion pertaining to whether the Claimant was totally disabled by pneumoconiosis, but not with regard to whether the Claimant was totally disabled. The Board also vacated this tribunal's findings with regard to the elements of total disability and total disability due to pneumoconiosis, and directed this tribunal to consider whether Claimant is totally disabled by his pneumoconiosis only after a separate finding that Claimant is totally disabled by a respiratory or pulmonary impairment under the recently amended §718.204(b). Finally, the Board advised this tribunal to specifically compare Claimant's current work with his previous coal mine employment pursuant to §718.204(b)(2) (pre-amended), citing *Harris v. Director, OWCP*, 3 F.3d 103, 18 BLR 2-1 (4th Cir. 1993).

All four of Claimant's pulmonary function studies and all four of his arterial blood gas studies produced non-qualifying results (D-9, 11, 26, 28, 51). Therefore, Claimant's has not established total disability pursuant to §§718.204(b)(2)(i) and (ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has also not proved total disability pursuant to Section 718.204(b)(2)(iii).

Prior to considering the reasoned medical opinions pursuant to §718.204(b)(2)(iv), this tribunal must compare the Claimant's current work with his previous coal mine employment. At the time of the hearing, Claimant was employed as a truck driver in road construction, stating, "All I do is I pull a truck up to a grinding machine. There's no strenuous work really involved in it." (Tr. 10). In regard to the physical components of that job, Claimant stated that he is required to hook a water hose up to a grinder and keep it "pulled up" about fifty to one hundred feet at a time on the road (Tr. 11). Claimant stated that this job was easier than coal mine employment, but testified that his income was substantially higher when he worked in the mines (Tr. 11-12). In comparison, Claimant was last employed in the coal mines as a drill operator and shot foreman, a position he held for approximately one year (Tr.12). As a drill operator and shot foreman, Claimant engaged in periods of moderate to heavy manual labor. He was required to crawl in low coal, regularly lift and carry fifty pound bags of powder and rock dust, and clean up (D-7, 10, 28, 51). Prior to working for Employer as a drill operator and shot foreman, Claimant worked in other coal mines as a foreman, miner operator, and general miner (D-2, 28; Tr. 13-18). In all of those positions, Claimant engaged in mild to heavy labor, including crawling in low coal, lifting and carrying fifty pound bags of powder and rock dust, operating various machines, and filling in for other workers (Tr. 13-17). Accordingly, this tribunal finds that Claimant's current work as a truck driver requires very little physical exertion as compared to his former coal mine employment, and does not provide comparable remuneration.

Drs. Ranavaya and Cohen opined that Claimant is totally disabled from resuming his former coal mine employment or any job with similar exertional demands (D-28). Dr. Ranavaya based his opinion on a detailed understanding of Claimant's last coal mine employment and the pulmonary function study and arterial blood gas study results he obtained during his February 10, 1995 examination of the Claimant. Dr. Cohen based his opinion on consideration of Claimant's duties as a drill operator and shot foreman and pulmonary function and cardiopulmonary exercise testing which indicated restrictive lung disease, gas exchange abnormality with exercise and low work capacity, and obstructive lung disease. Because both physicians provided well reasoned opinions based on the evidence before them, they are entitled to substantial weight.

Dr. Rasmussen, who noted that Claimant's last coal mine employment required "considerable heavy manual labor," opined that Claimant's minimal to moderate loss of respiratory function as reflected principally by the impairment in oxygen transfer during exercise, would render him "totally disabled for performing very heavy manual labor." (D-10). Dr. Rasmussen did not specifically opine that the Claimant is totally disabled. Though somewhat equivocal, in that "considerable heavy manual labor" implies heavy in duration, and "very heavy manual labor" implies "heavy" in terms of intensity, this tribunal finds it reasonable to infer that Dr. Rasmussen concluded that Claimant is totally disabled from his last coal mine employment. Accordingly, because Dr. Rasmussen based his conclusion on the objective evidence before him, his opinion is persuasive.

On the other hand, Drs. Daniel, Zaldivar, and Fino opined that the Claimant is not totally disabled by a respiratory or pulmonary impairment. Based on Claimant's pulmonary function and arterial blood gas testing performed during his February 22, 1995 examination, Dr. Daniel opined that Claimant does not have evidence of significant pulmonary dysfunction, is able to maintain normal acid based balance oxygen concentrations and at a normal response to pulmonary work, and, that Claimant is, therefore, able to continue his last job as a mine foreman and drill operator without endangering his pulmonary health (D-26). Dr. Daniel's well-reasoned and documented opinion is based on the objective medical evidence before him and is entitled to significant weight. Dr. Zaldivar, who both examined the Claimant and reviewed extensive medical evidence, opined that Claimant's mild airway obstruction and restriction evidenced by his pulmonary function and arterial blood gas testing would not prevent Claimant from performing very heavy physical labor (D-51). Dr. Zaldivar understood the requirements of Claimant's last coal mine employment, and because he based his opinion on review of extensive medical evidence, his opinion is persuasive.

Based on extensive review of the majority of the medical evidence in this case, Dr. Fino opined that from a strictly pulmonary standpoint, while the Claimant has an obstructive impairment, his impairment is not of sufficient degree to prevent him from returning to his former coal mine employment or a job requiring similar effort (E-2, 8 at 10-12). Dr. Fino specifically acknowledged that, while Claimant's last coal mine job required some heavy labor, it was not of such degree or duration that Claimant's lungs would preclude his ability to perform it (E-8 at 12). Dr. Fino's well reasoned opinion based on extensive medical evidence and critical analysis of both the Claimant's pulmonary condition and the requirements of his former coal mine employment is persuasive and entitled to substantial weight.

Dr. Tuteur reviewed extensive medical evidence and opined that the Claimant's symptomology indicates that he is totally disabled from performing the tasks of a coal miner or work requiring similar effort (E-3). He further opined that if the quantification of his symptomology is correct in the medical evidence, such disability is the result of a respiratory or pulmonary impairment (E-3). However, during his deposition, Dr. Tuteur stated that Claimant is not disabled from a pulmonary standpoint (E-6 at 12). Dr. Tuteur provided no rationale for his differing opinions, and therefore, his opinion is equivocal and entitled to little weight.

The six reasoned medical opinions of record are split three and three with regard to whether the Claimant is totally disabled by a respiratory impairment. However, this tribunal finds most persuasive the opinions of Drs. Fino and Zaldivar based on their superior credentials in pulmonary medicine, analyses of medical evidence dating as far back as 1986 and including the most recent examination evidence from June 1998, and well-reasoned and documented opinions which were most consistent with the objective medical evidence. *See Church v. Eastern Assoc. Coal Corp.*, 20 BLR 1-8 (1996). Though well-reasoned, the opinions of Drs. Rasmussen and Ranavaya are not as persuasive because they are not board-certified in pulmonary medicine. Moreover, Dr. Rasmussen did not review medical evidence developed subsequent to his February 1995 examination, and Dr. Ranavaya's opinion relied heavily on the pulmonary function testing administered during his examination of the Claimant, which Dr. Fino, who is credentialed in pulmonary medicine, invalidated upon review. Dr. Cohen, who is credentialed in pulmonary medicine, also provided a well-reasoned opinion based on the evidence before him; however, as discussed earlier, Dr. Cohen did not indicate consideration of all the objective medical evidence before him and was unable to review evidence developed subsequent to February 1995 which Dr. Tuteur analyzed as indicating improved pulmonary function. Accordingly, because the preponderance, though perhaps slight, of the reasoned medical opinions indicate that Claimant's pulmonary impairment is not significant enough to prevent him from returning to his former coal mine employment as a drill operator and shot foreman, this tribunal finds that Claimant has not established that he is totally disabled by a respiratory or pulmonary impairment under §718.204(b)(iv). Therefore, Claimant has not established a material change in conditions in this regard since the denial of his initial claim. Since Claimant has not established either the existence of coal workers' pneumoconiosis or a totally disabling respiratory or pulmonary impairment attributable thereto, or a material change in conditions since the denial of his last claim, he is not entitled to black lung benefits.

Attorney's Fee

The award of an attorney's fee under the Act will be approved only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services of an attorney rendered to the Claimant in pursuit of this claim.

ORDER

The claim of William C. Griffith for benefits under the Act is denied.

A

EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20001.